5230 Indirect Medical Education Adjustment Percentage

Indirect medical education costs will be included in the hospital-specific rate, with the "indirect medical education adjustment percentage" being calculated using the following formula:

$$1.89 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1 \right]$$

Base Data For In-State Hospitals. For hospitals located in Wisconsin, current available data required for the formula will be acquired from hospital Medicare intermediaries. If such data cannot be acquired, then the indirect medical education adjustment will be determined from the cost report used for the graduate medical education cost payment described in section 5500. Whichever is the data source, if the data used is from a cost report period which is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its indirect medical education adjustment based on a more current cost report period. (For combined hospital operations, see below.)

No Audited Cost Report Available. For hospitals for which there is no audited cost report available, an estimated indirect medical education payment will be calculated based on the best available hospital data (e.g., unaudited cost report, financial statements). The indirect medical education payment will be adjusted retrospectively when audited data becomes available.

For Recent Hospital Combinings. A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. If the needed audited data is not available for the combined operation, an estimated or interim indirect medical education (IME) adjustment will be calculated. The IME adjustment will be recalculated when an audited cost report for a full fiscal year of the combined operation becomes available to the Department. The adjustment will be effective the first day of the month following the month in which the combination was consummated. The amount of retrospective payment or recoupment resulting from the IME recalculation will be determined as follows where:

ADJIME = The IME adjustment percentage calculated from audited data
INTIME = The interim IME adjustment percentage
BASEPAY = Payments made to the hospital at the hospital's specific base rate applied to the applicable DRG weights and excluding outlier payments of §5300, capital cost payments of §5400 and direct medical education payments of §5500.

Formula: (ADJIME - INTIME) / (INTIME + 1.00) X BASEPAY = If positive amount, payment due hospital
or
If minus amount, recoupment from hospital

Other Adjustments. If a hospital terminates, starts a medical education program or significantly expands a medical education program, it may request an administrative adjustment under section 11900, item D.

5240 Disproportionate Share Adjustment Percentage

5241 General.

Extra payments are provided to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5242 Obstetrician Requirement.

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

5243 Medicaid Utilization Method.

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update without a hospital requesting the adjustment. In contrast, take note that a DSH adjustment under the low-income utilization method of section 5244 must be requested by the hospital. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formulas. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate plus the amount of one standard deviation is S in the following formulas. Finally, a "proportional increase factor" is calculated by first identifying the greatest Medicaid inpatient utilization rate (M) among hospitals in the state and then applying the following formula:

(5.5% minus 3%) / ($M_{greatest}$ minus S) = Proportional increase factor (F).

Qualifying Hospital Under Medicaid Utilization Method: A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

Hospital Specific Adjustment Calculated: All qualifying hospitals are provided a minimum 3% DSH adjustment. A 5.5% disproportionate share adjustment percentage is provided for the hospital with the highest utilization rate ($M_{greatest}$). Through use of the proportional increase factor (F), the following calculation provides an increase to a hospital's DSH adjustment percentage in proportion to the extent a hospital's utilization rate (M) exceeds the statewide mean-plus-one-standard-deviation (S).

A hospital's "DSH adjustment percentage" is calculated according to the following formula:

[(M minus S) x F] + 3% where M = Hospital's Medicaid inpatient utilization rate
S = Statewide mean-plus-one-standard-deviation
F = Proportional increase factor

*Adjustment for **Certain IMDs***. The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) **which qualifies** for a disproportionate share hospital adjustment and has an average length of stay that exceeds 60 **days for** Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by **Medicare are** excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 1996, the base will be the rate year July 1, 1994 to June 30, 1995.

Medicaid Inpatient Utilization Rate. For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

Substitute Page

Medicaid inpatient days (the numerator) will include Medicaid HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.

Medical Assistance patient days in the numerator shall not include any days of inpatient stays which were covered in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMAP would have paid for the stay.

Some MA recipient stays, which are not covered in full or part by Medicare, may be paid fully or partially by a third party insurance payor and\or by a recipient's MA eligibility spend-down funds. If the hospital stay is paid in full, then the days of the recipient's stay will not be included in the numerator as an MA patient day. If the hospital is not paid in full and the WMAP reimburses the hospital for the unpaid balance, then all days of the stay will be included in the numerator as an MA patient day to the extent that the days of the stay were allowed by the WMAP.

Base Data For In-State Hospitals. For hospitals located in Wisconsin, the number of total inpatient days, MA inpatient days and MA HMO inpatient days will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its disproportionate share adjustment based on a more current audited cost report. The statewide mean Medicaid utilization rate and the standard deviation amount will not be recalculated to include the MA utilization rate resulting from the administrative adjustment. For the base cost reports to be used for hospitals combining operations, see section 5860.

The hospital must report recipient inpatient days of other state's Medicaid programs for the period of the audited cost report. For this, the hospital must submit auditable data acceptable to the Department by the April 30th prior to the annual rate update. This due date may be extended by the Department's notice to all Wisconsin hospitals.

Base Data For Major Border Status Hospitals. For major border status hospitals, the number of inpatient days shall be from the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. The Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Inpatient days of WMAP recipient stays will come from Department payment records. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5860.

5244 Low-Income Utilization Method.

A hospital with a low-income utilization rate exceeding 25% may also qualify for a disproportionate share adjustment. A hospital has to specifically request the Department to be considered under this method for a disproportionate share adjustment. However, if a hospital qualifies for an adjustment under the Medicaid utilization method but requests an adjustment under the low-income method, the resulting lower adjustment percentage will be used. (See section 5246)

A hospital's "low income utilization rate" would be the sum of the following two percentages (next page), calculated as described on the next page. The Department will designate the cost reporting period.

First Percentage. Total payments from Medicaid to the hospital and total county general assistance program payments to the hospital for inpatient and outpatient services plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period. Revenues shall be net revenues after deducting bad debts, contractual allowances and discounts, that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross. Revenues shall also exclude recorded charges for charity care.

Second Percentage. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in a cost reporting period, less the portion of any cash subsidies described above in the period reasonably attributable to inpatient hospital services in the same period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period.

Charity Care. Charity care means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following: (1) care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care; (2) contractual adjustments in the provision of health care services below normal billed charges; (3) differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners; (4) hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or (5) bad debts. Bad debts means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

Adjustment Factors. The following table lists the disproportionate share adjustment factor for each threshold percentage of the low-income utilization method.

Low-Income Utilization Rate	*Adjustment Percentage*
25.0% through 43.99%	3.0%
44.0% through 62.99%	3.5%
63.0% through 81.99%	4.0%
82.0% & greater	4.5%

The hospital has to provide auditable data acceptable to the Department which is necessary to calculate the above two percentages. For annual DRG rate updates effective on and after July 1, 1992, a hospital must submit auditable data acceptable to the Department by the end of the second month prior to the effective date of the annual rate update. (For example, for a July 1, 1995 rate update, the due date is April 30, 1995.) Data received after the due date may be excluded from determination of the disproportionate share adjustment.

5246 Which Method Allowed.

A hospital will only be allowed an adjustment either under the Medicaid utilization method of §5243 or under the low-income utilization method of §5244. If the Department determines a hospital qualifies for a disproportionate share adjustment under the Medicaid utilization method but the hospital requests an adjustment under the low-income method, the method which provides the lower disproportionate share adjustment percentage shall be used.

5248 Public Notice.

A listing of hospitals qualifying for an adjustment and the amount of the adjustment will be published in the Wisconsin Administrative Register.

5260 Rural Hospital Adjustment Percentage

5261 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 11900, items K, L and M. Critical access hospitals under section 5900 are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a HCFA defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

For criteria item 1 above. The reclassification to an urban wage area, of a hospital which is located in a rural wage area, shall be rescinded by the Department if the urban wage area index to be applied to the hospital is lesser than the rural hospital adjustment. This allows the hospital to receive the urban wage adjustment or the rural hospital adjustment, whichever is greater. (Reference section 5226.)

For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year of the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a HCFA defined metropolitan statistical area (MSA) or which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate.

For criteria item 5 above. The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5860.

5262 Adjustment Percentage.

The amount of the rural hospital adjustment will be based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation. The resulting Medicaid utilization rate shall be used to determine the adjustment percentage for the hospital-specific DRG base rate according to the following table.

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage Effective On and After July 1,1999
Up through 4.99%	6.00%
5.0% through 9.99%	12.00%
10.0% through 14.99%	18.00%
15.0% and greater	24.00%

TN # 99-013
Supercedes TN# 98-013
Approval Date May 16, 2000
Effective Date 7/1/99

5270 Institutions for Mental Disease (IMD) Hospital Length of Stay Adjustment

A length of stay (LOS) adjustment is provided to the hospital specific DRG base rate of qualifying IMD hospitals. This adjustment applies for the rate year beginning July 1, 1999. To qualify, an IMD hospital's average length of stay for psychiatric DRG stays must exceed the average length of stay of all psychiatric DRG stays in the hospitals' peer group described in section 5150. The amount of the adjustment is determined according to the calculation and amounts described in this section.

((Hospital's LOS / Peer Group LOS) – 1.00) * .90 = IMD Length of Stay adjustment ratio

An IMD hospital qualifies for this adjustment only if the resulting adjustment ratio is a positive amount.

Hospital's LOS is the amount that is calculated by dividing the hospital's number of days of qualifying stays by the number of qualifying stays. Qualifying stays meet the following criteria.

(1) The stay was covered in full or in part by the WMAP's DRG based payment system.
(2) The stay was assigned (or grouped) to a DRG in MDC 19, the medical diagnostic category (MDC) for mental diseases and disorders.
(3) The stay is 60 days or shorter in length. Stays exceeding 60 days are excluded.
(4) The WMAP recipient was discharged from the hospital in the rate year beginning two years prior to the current rate year. For example, for the adjustment for the rate year beginning July 1, 1999, discharges in the rate year July 1, 1997 to June 30, 1998 are used. The number of days of these qualifying stays are used in the calculation without regard as to when the recipient was admitted to the hospital.

Peer Group LOS is the amount that is calculated by dividing the number of days of the qualifying stays by the number of the qualifying stays for the respective hospital's peer group described in section 5150. Qualifying stays meet the following criteria.

(1) The stay was covered in full or in part by the WMAP's DRG based payment system.
(2) The stay was assigned (or grouped) to a DRG in MDC 19, the medical diagnostic category (MDC) for mental diseases and disorders.
(3) The WMAP recipient was discharged from the hospital in that period from which claims were used to establish DRG weights for the current rate year. This period of claims used is described in section 5140. For example, for the adjustment for the rate year beginning July 1, 1999, the claims used for establishing DRG weighting factors are from the three year period July 1, 1995 to June 30, 1998. The number of days of these qualifying stays are used in the calculation without regard as to when the recipient was admitted to the hospital.

Each item (1) above excludes recipient stays that are: (a) covered by a managed care organization (MCO or HMO) under contract with the WMAP; (b) paid in full or part by Medicare (Title 18); or (c) stays for which the WMAP made no payment due to the stay being covered by some other payor such as private hospitalization insurance.

5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM

5310 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments and length-of-stay based outlier adjustments are provided. Each is described in detail below. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

The Department may evaluate the medical necessity of services provided and appropriateness of length of stay for all outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

5320 Cost Outliers

5321 Qualifying Criteria.

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary

2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.

3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 1992.

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 5,235	$ 31,410
Hospital Institutions for Mental Disease (IMDs)	$ 5,460	$ 31,633

4. Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to, cases treated at rehabilitation hospitals and State-operated IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5322 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see §5860.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

For Major Border Status Hospitals. For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided Wisconsin Medicaid recipients by the hospital based on the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5860.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average Wisconsin state-wide cost-to-charge ratio which is the ratio of the total Wisconsin state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

5323 Outlier Payment Calculation.

Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. An example of a cost outlier calculation is presented in appendix section 24500.

1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's cost-to-charge ratio.

2. The allowed excess claim costs will be calculated by subtracting the DRG payment and the hospital's trimpoint from the claim costs.
(Claim cost - DRG payment - Trimpoint = Excess cost, must be positive to qualify).

3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor of 77%. The variable cost factor for burn cases will be 97%. If the hospital is a disproportionate share hospital, the variable cost factor will be increased by 77% of the hospital's disproportionate share adjustment percentage.

5324 Bed Count, Source and Changes.

For rate years beginning on and after July 1, 1992, the trimpoint amount for each hospital shall be established effective July 1 of the rate year based on the bed count on file with the Department's Division of Health, Bureau of Quality Compliance, as of July 1 of the respective rate year. The hospital may request an administrative adjustment under section 11900, item A, to correct errors by the Department in establishing the appropriate trimpoint.

If a hospital changes its bed count after July 1, any change in the trimpoint amount will not be effective until July 1 of the subsequent rate year. The hospital must provide written notice of its change in bed count to the Bureau of Quality Compliance in sufficient time that the notice is received by the Bureau on or before July 1 of the rate year. The hospital should, but is not required to, provide a copy of the notice of the change to the Department's Division of Health, Bureau of Health Care Financing.

5330 Length of Stay Outliers

5331 Qualifying Criteria.

For a hospital's claim to qualify for length of stay outlier payment, the following criteria apply:

For disproportionate share qualifying hospitals (under section 5240):

1. The hospital qualified for a disproportionate share adjustment at any time during the period of the stay, and
2. The claim is for inpatient services for a child who was under six years of age on date of discharge, and
3. For discharges on and after July 1, 1994, the length of the child's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

For all hospitals:

1. The claim is for inpatient services for an infant who was under one year of age on date of discharge, and
2. For discharges on and after July 1, 1994, the length of the infant's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

5333 Request for Length of Stay Outlier Payment.

Under administrative adjustment P in §11900, a hospital may request a length of stay outlier payment. The hospital must submit a claim for the stay to the Department's fiscal agent. In addition, the hospital must submit a request for a length of stay outlier payment to the Department with a copy of the claim. The Department will determine if the claim qualifies for an adjustment and will calculate the amount of adjustment.

Hospitals should send requests for a length of stay outlier adjustment to:

Hospital Unit,
Bureau of Health Care Financing,
P. O. Box 309,
Madison, WI 53701-0309.

Due Date. The request for this adjustment must be delivered to the Department within 180 days after the date the recipient is discharged from the hospital. This due date applies without regard as to whether or not a claim for the stay has been paid by the Department's fiscal agent.

5334 Calculation of Length-of-Stay Outlier Payment.

The claim charges will be adjusted to cost pursuant to paragraph 5320.2 above. The cost will be divided by the length of the stay to determine the cost per day. To calculate variable costs, the cost per day will be multiplied by 77% plus 77% of the disproportionate share percentage. The resulting variable cost per day will be multiplied by the number of days which exceed the threshold days to determine the outlier payment to be made.

If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM -------

5410 General

As of July 1, 1997, an amount for capital costs is added to a hospital's specific base DRG rate. For Wisconsin hospitals and major border status hospitals, this capital payment amount is prospectively established based on an individual hospital's past capital costs. Prior to July 1, 1997, the capital payment was prospectively determined and paid through a monthly payment without regard to the number of WMP recipient discharges during the month.

5430 Calculation for Hospitals Located In Wisconsin

Base Cost Report. The capital cost payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the capital cost payment amount pursuant to section 11900, item B.

An administrative adjustment is provided in section 11900, item C, for major capital expenditures incurred after the beginning of the base cost reporting period.

For combining hospitals, section 5480 below describes the cost report to be used for calculating the capital payment.

No Audited Cost Report Available. For hospitals for which there is no audited cost report available, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

Calculation. The capital payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 23000 of the appendix.

1. The capital cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient capital costs to total allowed inpatient costs. These amounts are readily identifiable in the base cost report.

2. The resulting WMP capital cost from step 1 is reduced by 5% except for a hospital qualifying for an exemption under section 5450.

3. The amount from step 2 is inflated through the rate year by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.

4. The amount from step 3 is divided by the number of WMP recipient discharges for the period of the audited cost report.

5. The resulting amount per discharge is divided by the average DRG case mix index per discharge.

6. The result from step 5 is the hospital's specific base capital payment at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.